DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis and developing a treatment plan. Please complete these forms as best you can. We will have the opportunity to discuss them at your appointment.

TODAY'S DATE:

NAME	DATE OF BIRTH	AGE
WORK PHONE	**HOME PHONE**	
ADDRESS		
SPOUSE'S NAME	**WORK PHONE**	**CELL PHONE**

Have you been seen by any of the professionals listed below for emotional/behavioral problems such as depression, anxiety, etc? Please check and list all that apply:

Psychiatrist _____
Primary Care Physician _____
Therapist _____
Psychologist _____

Please specify the type of treatment received: _____

Why are you seeking professional help at this time:
_____
_____
_____

Outpatient Treatment:
Physician/therapist Address Duration of treatment From To
_____
_____
_____

Inpatient Treatment:
Facility Name Address Duration of hospitalization
_____
_____
_____

Please check any of the following symptoms that you are experiencing:

Frequent crying____sadness____ anxiety____fearfulness____upset stomach____ frequent headaches____chronic pain___obsessive thinking___panic____worry___difficulty concentrating____low energy___nightmares____grief____indecisiveness____poor appetite____overeating____too much energy___distractable____isolation____irritability___explosive anger____trembling____sweating___ chills___fidgeting__

memory problems____difficulty completing tasks____overspending____nightmares____tiredness___
hopelessness___sweating___difficulty maintaining relationships___social fears___trust issues____
frequent job changes____inability to enjoy___lack of interest____careless mistakes____TMJ_____
early morning awakening____ mood swings____ feeling misunderstood ___Other_____

Approximately how long have you been experiencing these symptoms?

What sources of stress exist for you? Job stress____ Relationship stress____ Parenting stress____
Financial stress____ Internal stress____ Life changes____ Losses____ Boredom____ Guilt____

What sources of support do you have?
_____

List any stressful or traumatic events in your life which may have affected your development and ability to function (i.e., birth of sibling, death in the family, divorce, illnesses, frequent school changes, witnessing a trauma, abuse, neglect).

Incident age comments
_____
_____
_____
_____

EDUCATIONAL PLACEMENT:

Did/do you experience any problems in school? _____ No _____ Yes If yes, please describe:
_____

Have you repeated any grades? _____ No _____ Yes If yes, please describe:
_____

Were you ever in any type of special education class? _____ No _____ Yes If yes, please describe:
_____

Have you had any behavior problems? _____No _____ Yes If yes, please describe:
_____

SOCIAL HISTORY:

Married: ____ No ____ Yes Divorced: ____ No _____ Yes # of marriages _____

Children: ____ No ____ Yes Ages_____ # living with you ____

Have you had difficulty with relationships/friendships? Please describe.
_____
_____

Do you smoke cigarettes? _____ No _____ Yes

Do you currently use any type of drugs? _____ No _____ Yes If yes, what types of drugs and how much per day? _____

Do you currently drink alcohol? _____ No _____ Yes If yes, what type of alcohol and how much per day? _____

Any history of legal problems? Please Specify

_____

FAMILY PSYCHIATARIC AND MEDICAL HISTORY

Specify which family members suffer from mental health problems or listed medical problems.
Relationship to patient Medications (specify) Hospitalizations

_____

Depression

_____

Bipolar Disorder

_____

Anxiety Disorder

_____

Schizophrenia

_____

Eating Disorder
Anorexia/Bulimia

_____

Learning Disorder

_____

Substance Abuse
Alcohol/Drugs

_____

ADHD

_____

Suicide attempt or
Completion

_____

OCD/Obsessive
Compulsive Disorder

_____

Legal Problems

_____

Violent Behavior

_____

Tourettes/tic Disorder

_____

Obesity

_____

Heart Problems

_____

Epilepsy/Seizures

_____

Thyroid Problems

_____

Other: specify type

_____